ROANOKE VALLEY
ENT
& ALLERGY

MEDICAL RECORDS REQUEST FORM

Patient's Name: _____ Patient's Date of Birth: _____

I hereby request and authorize the release of my medical records to the following:

Roanoke Valley ENT & Allergy
4633 Brambleton Ave.
Roanoke, VA 24018
Tel: (540) 655-1888 | Fax: (844) 212-0402

Please provide the facility name, address, phone number & fax number you are requesting your records be sent from:

_____

_____

_____

Please indicate your specific medical record request:

_____ Medical Records

_____ X-ray films, CT Scans, MRI's, and other radiology services including reports

_____ Pathology slides and reports

_____ Radiation/Chemotherapy records and doses

Patient's Signature: _____ Date: _____

Paul Lenkowski, MD, PhD ● Carrie D. Miller, MS
Hannah Seldomridge, PA-C ● Allison Clemmer, PA-C
4633 Brambleton Ave., Roanoke, VA 24018
Tel: 540-655-1888 Fax: 1-844-212-0402